Regional Medical Center
Blue Ribbon Panel Final Report

September 27, 2007

A C Wharton, Jr.
Shelby County Mayor

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Shelby County Government

A C Wharton, Jr.
Mayor

September 27, 2007

Ladies and Gentlemen:

In May of 2007 I convened a task force to develop long and short-term sustainable strategies for the continued operation of the Regional Medical Center at Memphis (the MED). As the numbers of the uninsured throughout our region climb, the ability of the MED to stretch the already limited resources to meet these needs diminishes.

In addition to its critical safety net function for the uninsured, the MED houses the Level I Trauma Center for our region, nationally recognized high risk obstetric and neonatology center, regional burn center, Sickle Cell treatment center, comprehensive HIV healthcare services and serves as a primary teaching hospital for the University of Tennessee Medical School in Memphis. As the MED has continued to provide this wide range of services, the percentage of its patients classified as self-pay has increased dramatically. In order to limit its operational losses key capital and infrastructure issues have been postponed and the need to address these needs is now critical.

In recognition of the critical role of the MED as the provider of vital health care services limited by available resources, I convened the Blue Ribbon Panel on The Regional Medical Center at Memphis. The scope of their task was to study and make recommendations that would assist in developing sustainable strategies for operations and funding for the MED

The members of the Mayor's Blue Ribbon Panel on the Regional Medical Center at Memphis included industry leaders, political leaders from our region, representatives from the MED and the University of Tennessee Center for the Health Sciences and community leaders. The panel was not limited in its consideration of any alternative during their deliberation process. All have without exception dedicated themselves devoting countless hours to study and deliberation throughout this process.

I extend my sincere appreciation to all who have participated and welcome the results of their hard work.

Sincerely,

A C Wharton, Jr.
Mayor

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Mayor's Blue Ribbon Panel on the Regional Medical Center at Memphis
MEMBERS

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Former Commissioner of Health, State of Tennessee

Cristie Travis, Chairman Subcommittee A
Chief Executive Officer, Memphis Business Group on Health

Yvonne Madlock, Chairman Subcommittee B
Director of Health Services, Shelby County Government

Mr. Gene Holcomb, Chairman Subcommittee C
Regional Medical Center Board

Mr. David Archer
Chief Executive Officer, Saint Francis Hospital

Ms. Elizabeth Bradshaw
Executive Director, Regional Medical Center Healthloop

Mr. Steve Burkett
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Mr. Michael Cates
Executive Vice President, Memphis Medical Society

Mr. Nathan Essex
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Mr. William C. Rhodes
President & CEO, Autozone, Incorporated

Mr. Gary Shorb
President & CEO, Methodist Healthcare

Mr. Travis Smith
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Mr. Jose Velazquez
Executive Director, Latino Memphis

Dr. Pat Wall
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Mr. Burt Waller
Executive Director, Christ Community Health Center

Mr. Mark Yates
First Horizon National Corp

Dr. Kenneth S. Robinson, Chairman
Mayor's Blue Ribbon Panel on the Regional Medical Center at Memphis

Introduction

From inception, the charge to all participants from Mayor Wharton was to develop recommendations regarding the best structure for meeting the healthcare needs of our indigent citizens. Options for consideration were not limited in scope. The task was to define the role of The MED, to determine if the continued presence of The MED was to be viable in the short- and long-term, and to recommend strategies for the funding and delivery of the recommended services on a sustainable basis. Critical and central to the Panel's process was the Mayor's intentional inclusion on the Panel of key stakeholders in health services delivery, medical education, political jurisdictions, and the local and regional economy. The willingness of representatives from all arenas impacted by the service delivery of The MED to devote considerable time to this effort is to be applauded, and credited for the deliberated consensus represented by the Panel's recommendations. Such broad-based, blue-ribbon level involvement indicates the importance of The MED to the health and welfare of our citizens locally and regionally.

Executive Summary

The Regional Medical Center at Memphis is our regional safety net hospital. Approximately 400 beds out of the 610 licensed beds are in operation. The MED jointly operates with the Shelby County Health Department a network of 10 community based primary care clinics designated as the Health Loop, and directly operates The MEDPlex – Ambulatory Care Center. There are currently seven Centers of Excellence at The MED; The Elvis Presley Memorial Trauma Center, The Sheldon B. Korones Newborn Center, The Firefighters Regional Burn Center, The Regional Rehabilitation Hospital, The High-Risk Obstetrics Center, The Bariatric Center, and The Wound Center. The Trauma Center, a Level I designation unit serving west Tennessee as well as the states of Mississippi and Arkansas is one of the nation's busiest. The MED serves as a major clinical training site for health professionals, in partnership with the University of Tennessee School of Health Sciences and the University of Tennessee Medical Group.

Challenges for The MED, addressed by The Blue Ribbon Panel, include the following:

- Increased demand for services by the uninsured
- Federal law and public policy necessitating service delivery regardless of ability to pay
- Difficulty gaining access to capital
- Constraints on federal and state funding
- Competition for local government funding
- Strains on emergency services and the access of emergency room services for non-emergent needs
- Acquisition and stabilization of sources of regional public funding and other revenue and reimbursement sources

The Blue Ribbon Panel on The MED has spent the last 120 days examining available services and capacity issues in the provision of healthcare to the indigent and uninsured to identify service gaps that exist in this network. In addition, the Panel carefully explored the scope of medical services currently provided by The MED, and sought to develop consensus on the future direction of The MED. Furthermore, current funding patterns have been analyzed and funding gaps have been identified and addressed.

Blue Ribbon Panel Core Recommendations

I. **The development of a more robust system for the delivery of health and healthcare services to the medically indigent** in Shelby County will serve to both a) improve the health and the quality of healthcare for the citizens of Memphis/Shelby County, and b) more appropriately utilize the unique assets which The MED provides to the network of healthcare providers, better positioning The MED for sustainability.

II. **The MED should maintain its core service mission**; while exploring the elimination of underutilized medical services, and further narrowing its service mix. Priority should be placed on the provision of high quality patient care to its primary geographic service area of Shelby County, particularly focusing on the efficiency of patient care operations associated with its teaching programs.

III. For highly specialized, tertiary services, **The Med should continue to serve as a regional provider**, retaining its Level I Trauma Center, and continuing to operate and invest in the enhancement of its Centers of Excellence, while reviewing the latter for their sustainability.

IV. In addition to continuing the current management's effective approach to maximizing operational efficiencies, **The MED must secure additional recurring and sustainable funding subsidies, which will unequivocally be required** in order to continue current operations, given its unique patient and payor profile as a public hospital. Over and above the need for operational subsidies, the critical need for capital for equipment and infrastructure replacement and improvements must be addressed, in order for The MED to provide high quality healthcare to the patients it serves, and to maintain the most valuable assets it brings to the State of Tennessee and to the regional healthcare network.

V. **Exploration of the potential for developing new structures** for healthcare management, operations, and the provision of medical services, including **creative partnerships, collaborations or affiliations with other local hospitals**; yielding both patient care efficiencies and fiscal efficiencies, and facilitating The MED's focus on its areas of high priority.

The Report of The Mayor's Blue Ribbon Panel on the Regional Medical Center at Memphis

September, 2007

Background

The Regional Medical Center at Memphis is our regional safety net hospital. Approximately 400 beds out of the 610 licensed beds are in operation. Service delivery incorporates the hospital complex of 1.1 million square feet and a Quick Care Urgent Care Center. In addition The MED jointly operates with the Shelby County Health Department a network of 10 community based primary care clinics designated as the Health Loop and directly operates The MEDPlex – Ambulatory Care Center. The MEDPlex is composed of 26 specialty clinics and has 85,000 visits annually.

Centers of Excellence at The MED include the following:

- The Elvis Presley Memorial Trauma Center
- The Sheldon B. Korones Newborn Center
- The Firefighters Regional Burn Center
- The Regional Rehabilitation Hospital
- The High-Risk Obstetrics Center
- The Bariatric Center
- The Wound Center

The Elvis Presley Memorial Trauma Center, a Level I designation unit, serving West Tennessee and the states of Mississippi and Arkansas, is one of the nation's busiest, with more than 2000 admissions annually. In addition to its Centers of Excellence, The MED is known for its HIV and comprehensive sickle cell patient services. Other service measures include on an annual basis:

- Over 18,000 Inpatient Discharges
- 5,000 Births
- 200,000 Primary and Specialty Ambulatory Care Visits
- 65,000 Emergency Care Visits
- 300 Burn Center Admissions

The MED serves as a major clinical training site for physicians, nurses, pharmacists and other health professionals in partnership with the University of Tennessee School of Health Sciences and the University of Tennessee Medical Group.

Challenges for The MED include the following:

- Increased demand for services by the uninsured
- Difficulty gaining access to capital
- Constraints on federal and state funding
- Federal law and public policy necessitating service delivery regardless of ability to pay
- Strains on emergency services and the access of emergency room services for non-emergent needs
- Competition for local government funding
- Acquisition and stabilization of sources of regional public funding and other revenue and reimbursement sources

The Blue Ribbon Panel on The MED has spent the last 120 days examining available services and capacity issues in the provision of healthcare to the indigent and uninsured to identify service gaps that exist in this network. In addition, the Panel carefully explored the scope of medical services currently provided by The MED, and sought to develop consensus on the future direction of The MED. Furthermore, current funding patterns have been analyzed and funding gaps have been identified and addressed.

The information contained in this report is a compilation of committee analysis and discussion, with recommendations for both system-wide healthcare delivery options, as well as for options related to service provision at The MED, itself. Because of The MED's central role currently in the system of indigent healthcare delivery, any reconsideration of its role or reconfiguration of its scope of medical services could not be accomplished responsibly without factoring in the County's responsibility for the health and healthcare of the uninsured and medically indigent. The Panel's recommendations associated with systemwide options carry significant funding needs that could not have been comprehensively addressed within the scope and timeframe of the Blue Ribbon Panel's charge. However, The Panel's report does provide The Mayor with a menu of options and considerations which inform several delivery mechanisms; which, in turn, could provide for sustainable, high quality service delivery at The MED, and produce positive funding scenarios for the hospital and the County.

Overall Conclusions

The intrinsic value of The MED as a key component of the overall healthcare delivery system both locally and regionally was affirmed and serves as the basis for the final Blue Ribbon Panel recommendations. The absence of The MED and all its component service units from the health care system both locally and regionally would create an untenable environment in which the patient demand would far exceed the capacity of the remaining hospitals and outpatient centers. The impact upon the uninsured, medically indigent and others in need of the critical services provided by The MED would be devastating. The negative impact on the University of Tennessee Center for the Health Sciences and the University of Tennessee Medical Group would also be significant. Therefore, the responsibility for supporting these needed services is a regional responsibility. Federal mandates require service delivery regardless of a patient's ability to pay. The MED receives funding from all levels of government for this purpose; however significant funding gaps exist and grow wider as costs of service delivery increase without corresponding funding increases.

The MED is unlikely to achieve adequate progress through a competitive advantage in most of its service lines. Any attempt in this regard would require an infusion of operational and capital funding and serious analysis regarding current and future impact. With limited ability to raise its own capital and the lack of significant additional government subsidies, constraints overwhelm the ability to pursue this option. While additional operational efficiencies continue to be developed, the resulting savings will not bridge the ever increasing funding gap and cannot be achieved without corresponding increases in government subsidies.

In order to provide the needed resources to improve the financial stability of The MED, it is The Panel's recommendation to begin a dialogue with other health service providers to determine the possibility of affiliation in order to achieve both economies of scale and be able to broaden the pool of resources available to sustain current and future operations. Through collaborations, best practices can be accessed to improve operational efficiencies and to enhance current Centers of Excellence, to achieve the best in patient quality of care. Additional recommendations were made with regard to the overall healthcare delivery system for the indigent in our community. These recommendations include processes and procedures to triage non-emergent patients to a more appropriate level of care or healthcare facility, the expansion of subspecialty and diagnostic services available in the Health Loop and community clinics, and securing long term acute care providers to reduce excessive inpatient days.

The Recommendations of the Blue Ribbon Panel

A. **The development of a more robust system for the delivery of health and healthcare services to the medically indigent** in Shelby County will serve to both a) improve the health status and the quality of healthcare for the citizens of Memphis/Shelby County, and, b) more appropriately utilize the unique assets which The MED provides to the network of healthcare providers, better positioning The MED for sustainability.

Specific Options:

1) Optimize outpatient access to preventive health, primary care, urgent care, specialty and subspecialty physician and diagnostic services for the medically indigent, by creating new healthcare access points, and expanding capacity for this service provision outside of The MED and the MedPlex, in a distributed network of the Health Loop Clinics and other community-based, primary care safety net providers.
2) Explore the development of new resources, or the redirection of eligible subsidies, to enhance outpatient services. Creatively ensure that revenues "follow the patient."
3) Decrease walk-in utilization of The MED's emergency department by individuals not requiring emergent care, by developing an EMTALA-compliant system of pre-ER triage, utilization management, referrals and facilitated appointments and access to enhanced outpatient services.
4) Establish emergency care facilities at The MED, distinct from The Trauma Center, and triage non-trauma patients to the appropriate level of care, provided at an appropriate cost of care.
5) Explore mechanisms and means to increase the participation of private sector subspecialty providers, and access to their services by the uninsured.
6) Create increased capacity and/or enhanced access for The MED's inpatients to Home Health, Nursing Home, Long Term Acute Care and outpatient pharmacy; decreasing length of stay and improving the patients' quality of care by providing appropriate levels of care in the most appropriate settings.
7) Outsource inmate healthcare.

Further exploration and potential investment in the enhancement of access to primary care, ambulatory specialty care, decentralized or distributed outpatient diagnostic services, and long-term care services will be critical to the future of The MED. This should reduce demands on the MedPlex and The MED for basic services, reduce scheduling delays, and lower patient costs in terms of time and travel.

B. **The MED should maintain its core service mission**, while exploring the elimination of underutilized medical services, and further narrowing its service mix. Priority should be placed on the provision of high quality patient care to its primary geographic service area of Shelby County, particularly focusing on the efficiency of patient care operations associated with its teaching programs. The Panel reaffirms that The MED's primary mission is patient care, with teaching as one of the mechanisms to effect quality care. The Panel further recommends emphasizing patient need for services over profitability. The MED's High-Risk Obstetrics services, Regional Perinatal Center, Loop Clinics, MedPlex Specialty Clinics and diagnostic services remain major assets to the County's healthcare delivery network.

Specific Options:

1) Eliminate cardiac catheterization and invasive heart procedures, radiation therapy and cancer treatment at The MED, given adequate and appropriate resources in the community to provide these services, and their underutilization at The MED.
2) Create new accountabilities and efficiencies in the teaching clinics, facilitating shorter appointment wait times, and increased availability of specialty care.

C. For highly specialized, tertiary services, **The Med should continue to serve as a regional provider**, retaining its Level I Trauma Center, and continuing to operate and invest in the enhancement of its Centers of Excellence, while reviewing the latter for their long-term sustainability.

Specific Options:

1) Maximize The MED's ability to access insurance reimbursement for trauma care
2) Explore the long-term impact of narrowing The MED's service mix by eliminating inpatient rehabilitation services, although the short-term fiscal impact of so doing is adverse.
3) Eliminate the Burn, Bariatrics, and Wound Centers of Excellence.
4) Alternatively, explore creating and marketing new Centers of Excellence to complement The Trauma Center - such as Centers for Neurology/Neurosurgery, Orthopedics, Joint Replacement and Pain Management – or building upon existing Centers such as The Burn Center to develop a Center for Plastics and Reconstructive Surgery; each with regional appeal and potential profitability.
5) If retained, The Burn Center may explore becoming a comprehensive center, treating children as well as adults; requiring strong clinical relationships with LeBonheur Hospital to ensure the provision of high quality services to pediatric patients.
6) If Comprehensive Sickle Cell services are retained, add 24/7 services which help prevent inpatient episodes by effective outpatient management of crisis episodes.

D. In addition to continuing the current management's effective approach to maximizing operational efficiencies, **The MED must secure additional recurring and sustainable funding subsidies, which will unequivocally be required** to continue current operations, given its unique patient and payor profile as a public hospital. Over and above the need for operational subsidies, the critical need for capital for equipment and infrastructure replacement and improvements must be addressed, in order for The MED to provide high quality healthcare to the patients it serves, and to maintain the most valuable assets it brings to the State of Tennessee and to the regional healthcare network.

Specific Options:

1) Solicit increased direct government subsidy from the State of Tennessee, targeting both operational and capital costs.
2) Maximize revenue from Mississippi and Arkansas, supporting all executive, legislative, regional policy, or federal approaches to narrow the gap between the level of reimbursement and cost of care provided to residents of those states; a ratio of 1:5 for Mississippi, and 1:11 for Arkansas the last fiscal year.
3) Explore all statutory, legislative and public policy approaches to generate and institutionalize recurring funding mechanisms for County subsidies.
4) Apply for federal Homeland Security funding, as the sole public hospital and Level I Trauma Center in the region available to respond to any mass casualty event.
5) Advocate for and support the work of the Tennessee Congressional Delegation to expand the availability of federal funding streams for care provided at The MED.

E. **Exploration of the potential for developing new structures or delivery systems** for healthcare management, operations, and the provision of medical services, including **creative partnerships, collaborations or affiliations with other local hospitals**; yielding both patient care efficiencies and fiscal efficiencies. Accessing savings from economies of scale will provide an opportunity for The MED to enhance service areas in which it is currently a priority provider of services.

Specific Options:

1) Pursue an affiliation with one or more established local hospitals, in such a manner and to the extent that would both protect the core mission of The MED, and also not jeopardize access to, or the magnitude of, existing sources of subsidy and other revenues.
2) Explore any opportunity to negotiate financial assistance from private hospitals either directly or through joint ventures or shared/contracted service methodologies.

Subcommittee Reports

Subcommittee A The Structure of Indigent Health Care Service Delivery for Shelby County and the Region

Subcommittee A, chaired by Yvonne Madlock, Director of Health Services, Shelby County, studied the overall health care delivery system for indigent citizens in Shelby County and the region served by the MED. The role and value of the MED locally and as a part of the comprehensive healthcare delivery system for the uninsured was a particular focus for Subcommittee A. The scope was further refined by frameworks adopted by Subcommittee B for their review of the service mission of the MED. Additionally, the role of the Health Loop Clinics and their relationship with the MED were also included in Subcommittee A's overall review.

Subcommittee A's charge was to recommend short and long term strategies that stabilize and improve the indigent health care service delivery for Shelby County and the mid-south region. Recommendations from this subcommittee were submitted to Subcommittee C for analysis regarding funding requirements.

Shelby County has a disproportionate number of uninsured or underinsured individuals when compared to other regions of Tennessee. For these individuals access to health, medical and hospital services has not been optimal. Utilizing emergency rooms as walk in clinics for non emergent health needs is common practice of long standing. While overall health status indicators are below national norms, these indicators are far worse among citizens with lower socioeconomic status. This population is predominantly African-American with increasing numbers among the Latino population. There are distressingly high rates of infant mortality, chronic and debilitating diseases, high incidence of sexually transmitted diseases, including HIV and lifestyle related preventable premature death.

While the State of Tennessee has established some new health insurance coverage programs for low income and uninsured children and adults, their impact will be marginal in Shelby County. There is no proposed federal plan that will alter this trend for Shelby County on the horizon.

The services provided by the MED are important to the health and well-being of all residents of Shelby County and the mid south region. Regional services, primarily known as centers of excellence are: trauma, burn, high risk OB and newborn, and HIV/AIDS. The MedPlex houses the MED's specialty clinics. Of local importance are: MedPlex diagnostic and specialty physician services, OB services (only OB hospital services within the I-240 loop) and access to inpatient care for the uninsured. The MED plays a vital role in the delivery of public health services supporting efforts which combat infectious disease, emergency response initiatives and the provision of medical care to inmates housed in local facilities. However, the current availability of services from the MedPlex is not particularly easy to access and many physician specialty services have extraordinary shortages.

The diagnostic and specialty physician services at the MedPlex are very important to other community health organizations which include the following: Christ Community Health Services, Church Health Center, the Health Loop and the Memphis Health Center.

Initially four scenarios were identified for consideration. These were

- Better Med
- Centers of Excellence and Triage
- Community Hospital
- No MED

BETTER MED SCENARIO

The service mission of the Med would change only slightly from its current mission. The recommended change would be the elimination of cardiac catheterization and invasive heart procedures, radiation therapy and cancer treatment as there are adequate and appropriate resources in the community to provide these services and they are not highly utilized at the MED.

The elimination of the services referenced would not solve the funding crisis of the MED. The current governmental subsidies would be insufficient to break even operationally and provide needed capital to update and replace outdated equipment and build or renovate needed infrastructure. All buildings would need to be seismically retrofitted. Inadequate staffing patterns would require additional resources and could perhaps require a mixed academic/staff model in partnership with the University of Tennessee Center for the Health Sciences,

CENTERS OF EXCELLENCE AND TRIAGE SCENARIO

In this proposed reconfiguration of the service mission of the MED, the current centers of excellence, along with Health Loop and MedPlex clinical services would be retained. The current triage function would be expanded to direct patients to other providers for care no longer provided by the MED. General inpatient care would no longer be provided at the MED. As the MED's ER and Trauma Center would no longer be the primary entry points for health services for the indigent, new primary care access points would be established in the community and the system of Health Loop Clinics would be expanded along with sub specialty options. Diagnostic services would be established in community primary care clinics.

This model would result in additional funding needs for expansion of services throughout the community and the clinics operated by the MED. The change in service mission would not eliminate the need for government subsidies or infusion of capital funding for equipment and infrastructure. The current staffing partnership with the University of Tennessee Center for the Health Sciences would be changed to a mixed academic/staffing model and would require additional physician coverage in areas retained. Service agreements would be developed with other providers as a part of the triage function to ensure quality of care is maximized and all care mandates are met.

COMMUNITY HOSPITAL SCENARIO

In this model the MED would serve the purpose of a primary/secondary mission medical center. The mission of the MED would focus more on preventive services and primary outpatient care. This would support community wide efforts to promote a healthier community. A 24 hour emergency care service would be available on a 24 hour 7 day a week basis, but only equipped for more routine emergency care. The Trauma Center would be eliminated, but the high risk OB and neonatal services would be retained. There would be limited inpatient beds as needed to support the redefined mission.

Higher level tertiary care patients would be transferred to other medical centers as determined through provider agreements.

This scenario would support basic patient care, eliminate more costly services. Extensive cooperation from other medical centers would be required. Many of the services eliminated are associated with a more favorable payor mix. Would still require operating subsidies for indigent and inmate medical care and infusion of capital funding for the remaining service areas.

NO MED SCENARIO

In this model the MED would be downsized and ultimately closed. The hospital assets would be liquidated, however, the Health Loop and MedPlex operations would remain.

As a result of this action approximately 18,000 admissions would have to be absorbed by other providers. This begins a catastrophic process that would have a devastating impact on our community and region. The formula by which states access federal funding for hospital care of the uninsured would be altered with potentially negative results. The graduate medical education function would be eliminated. Those in greatest need would be most adversely impacted if this scenario were implemented.

RECOMMENDATION FOR FUNDING ANALYSIS

The Better MED scenario was recommended by Subcommittee A as the highest priority for funding analysis by Subcommittee C. The second tier recommendation was that the MED retain high risk OB and neonatal services only, eliminating trauma and other emergency services.

Subcommittee B –Review the Possible Realignment of the Service Mission of the Regional Medical Center

Subcommittee B, chaired by Cristie Travis, Chief Executive Officer, Memphis Business Group on Health, reviewed the service mission of the MED in order to make recommendations regarding potential changes in the services provided by the MED.

As a framework for decision making and recommendations, consensus was achieved regarding a "*Direction of Travel*" to delineate priorities to support deliberations by the subcommittee. This is summarized as follows:

Direction	*Driving Strategy*
Patient Care	The objective for services at the MED is **patient care**. **Teaching** is one of the mechanisms to deliver care.
Medical Care	The focus of the MED's inpatient services, specialty clinics, emergency/trauma services is **medical care**. The MED will address the overall **health** of patients receiving these services and will provide services needed to slow the progression of diagnosed diseases and conditions.
Shelby County	The MED's primary geographic service area is **Shelby County**. For highly specialized, tertiary services, the Med will serve as a **regional** provider.
Narrow Service Mix	The MED's service mix will be **narrow** in scope, but will need to include the **broader** base of services required to provide quality care in these services.
Efficient Operations	**Efficient operations** will be considered most important when teaching needs result in inefficiency.

All of the directions adopted were rooted in the strong commitment to providing quality care. It was assumed that the MED supports all hospitals in Memphis providing the same standard of care for everyone in our community and the MED will provide quality patient care consistent with this standard.

Utilizing these designated priorities as a basis for considering service options for the MED, three scenarios were identified. They represent a continuum of possibilities.

One scenario considered the MED limiting its services to diagnostics, outpatient Health Loop Clinic services and MedPlex specialty clinic services. The second scenario included all services from the first scenario and added ER and trauma services and limited inpatient services required to support the trauma function. The third scenario included all services from scenario two and added comprehensive inpatient services.

These options were evaluated utilizing the priorities identified in the *Direction of Travel*, the ability to provide quality care, other available alternatives for the provision of patient services and feasibility. Consensus was generated by identifying services that must be provided by the MED, those which should be provided if adequate resources are available and those which would be eliminated from the MED's service mission. A table summarizing these services follows:

MUSTS	SHOULDS	DISCONTINUE
Outpatient Loop Clinics	(H) ER with Level 1 Trauma	Invasive cardiology and cardiac surgery
MedPlex Specialty Clinics	(H-M) Inpatient rehab	Cancer, including radiation therapy
Diagnostics	(M) Comprehensive Burn	
High Risk OB/Regional Perinatal Center	(M) Comprehensive Sickle Cell	
	(L) General medical/surgical	
	(L) Inmates	

(H) Indicates a High Priority (M) Mid Range Priority (L) Low Priority

Other recommendations include:

1. **MedPlex Specialty Clinics:** Capacity should be increased to reduce waiting times
2. **Diagnostics:** Basic diagnostics should be provided in the Loop system as well as the MedPlex and Med. This should reduce demands on MedPlex and Med for basic services, reduce scheduling delays, and lower patient costs in terms of time and travel.
3. **ER, with Level 1 Trauma:** Level 1 Trauma designation is preferred over Level II, for both quality of care (response time, specialty availability) and teaching reasons. To ensure Level I Trauma Center continues to meet national standards for care and delivery of services, the center should seek verification by American College of Surgeons.
4. **Comprehensive Burn:** If offered, should include pediatrics as well as adults, but only if strong clinical relationships with LeBonheur ensure provision of high quality services to pediatric patients. To ensure Burn Center continues to meet national standards for care and delivery, the center should seek verification by the American Burn Association.
5. **Comprehensive Sickle Cell**: If offered, should include 24/7 continuum of services that help prevent inpatient episodes through effective outpatient management of crisis episodes.

Additional Considerations

Consider how the following important services will be provided for M patients:

- Home Health
- Nursing Home (including SNF)
- Long Term Acute Care (LTAC)
- Outpatient Pharmacy

Recommendation for Funding Analysis

Subcommittee B joined with Subcommittee A to recommend the Better Med Scenario as the highest priority for funding analysis by Subcommittee C. This would include all services considered to be a level 1 or 2 priority as indicated in the previous table. The second tier recommendation was that the MED retain high risk OB and neonatal services only, eliminating trauma and other emergency services reflecting only the Level 1 priority services.

Subcommittee C - Develop Sustainable Revenue Options for the Regional Medical Center

Subcommittee C, chaired by Gene Holcomb, Chairman, Shelby County Health Care Corporation, analyzed the financial implications of the recommendations from the other two subcommittees. This subcommittee was responsible for analysis of the local and regional impact from suggested changes in service mission and delivery, with special attention given to the impact on healthcare delivery to indigent citizens.

Critical financial issues for the MED include the following:

1) cash – projections are as low as 20 days of cash available
2) operating deficit – There is a need for $70m to $80m subsidy to survive.
3) capital problem – Operating deficits have been offset with reductions in allowance for capital replacement for extended periods of time resulting in obsolete equipment and decaying buildings. Real capital needs are somewhere between $70m and $400m depending on the defined service mission for the MED.

The annual operating budget of the MED is approximately $300 million. Of that almost $100 million is provided in uncompensated care to local and regional residents.
The State of Tennessee provided $34 million in funding for the FY 2007 year consisting of the following:

- $18.5 million in Essential Access Hospital Payments (EAH) This formula rewards high rates of uncompensated care, while also taking into account hospital profitability
- $6 million in Disproportionate Share Hospital Payments (DSH) The allocation formula is similar to that for the Essential Access Hospital Payments.
- $7 million as a special state appropriation
- $2.3 million in designated Trauma Center Funding

A state allocation of revenue from the $.02 per pack cigarette tax instituted for the FY 2008 year for Trauma Center funding will produce a new funding stream to the MED, however several of the revenue sources received in FY 2007 from the State of Tennessee are non-recurring.

Shelby County for the FY 2007 fiscal year provided $28 million in funding to the MED from its general fund revenue. Subsidy payments from Mississippi for FY 2007 were $2.3 million against a net cost of uncompensated care of $11 million. Payments from Arkansas for FY 2007 were $987,000 against a net cost of uncompensated care of $11 million.

In addition to ongoing operational issues, short and long term capital needs were reviewed. The following projects are part of a long term plan developed by the MED prior to the convening of the Blue Ribbon Panel. Projects outlined will replace old and deteriorating buildings, improve service efficiency and patient transfer efficiency, add needed parking and complete seismic retrofitting of all remaining older facilities. The MED is currently at its current inpatient bed capacity.

New surgery (scope includes emergency, 12 OR's, trauma & ICU)	$100,000,000
Vacate Adams	60,000,000
Demolish Adams	1,000,000
New Women's Center	119,000,000
Demolish the Rout Bldg	1,000,000
New Main Entrance	2,000,000
New Parking (500 spaces)	15,000,000
Seismic Retrofit	20,000,000
Infrastructure	32,000,000
Total All Projects	$350,000,000

In order to analyze in greater detail the financial impact of service recommendations from Committees A and B, a request was made for Committees A & B independently or preferably jointly to finalize two scenarios to present to the full panel. One should be "A Better MED"; the other a consensus of what they envision as a modified Scenario 2. It is essential that sufficient information be made available comparing all aspects of the two scenarios to allow the Blue Ribbon Panel to accurately access not only the financial, social and service impacts of these scenarios on the MED, but the impact on the entire regional spectrum of health care service delivery including required funding from Shelby County and other stakeholders.

Subcommittee B then evaluated options regarding the financing of operating expense deficiencies and availability of resources to either provide for capital expenditures or to guarantee/ repay related debt must be provided by some combination of the same or similar sources.

While many combinations and variations can be considered, two options received consideration discussion. These were solicitation of increased direct government subsidies from the state governments, apply for Homeland Security funding to the extent possible, attempt to negotiate financial assistance from private hospitals either directly or through joint venture or shared/contracted service methodologies, with any remaining shortfall assumed by County and State governments or explore the feasibility of an affiliation with one or more local hospitals in a way that would protect the mission of the MED to the extent possible and ensure continued access to funding sources.

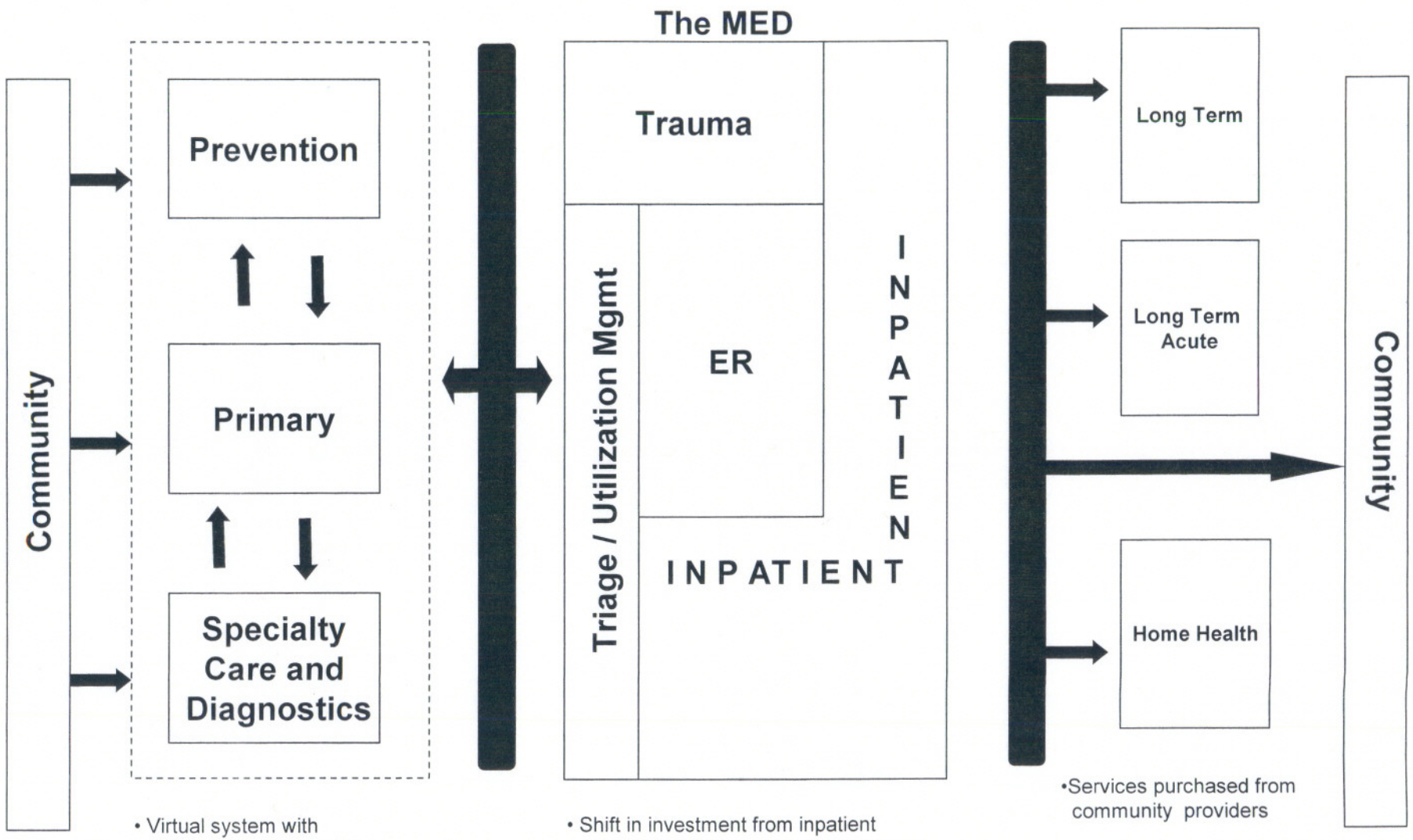
Costs associated with proposed service mission scenarios for the MED are as follows:

	Funding Operating Losses	Equipment	Infrastructure
Current Med	$70 -$80	$50 - $70 yr 1, $25 thereafter	$350
Centers of Excellence & Triage	$37	$53 - $83 yr 1, $25 thereafter	$350
"Better Med" – Primary Care Focus	$92	$57 - $87 yr 1, $25 thereafter	$350
"Better Med" – w/o Selected Services	$97	$57 - $87 yr 1, $25 thereafter	$350

Recommendation for Full Panel Consideration

When funding options were considered the option considered to be the most probable for further development was the pursuit of an affiliation with one or more established hospitals. This would access savings from economies of scale and provide an opportunity for the MED to enhance areas where it is currently a priority provider of services. Additional effort could be directed utilizing government and other funding sources to enhance clinic services to more efficiently serve the needs of the uninsured that does not utilize emergency room care for non emergent medical needs. The enhancement of specialty clinics would aid in this effort. The end result would be an enhancement in the quality of care for all patients treated, improvement in fiscal stability both short and long term and the ability to access capital resources on an ongoing basis to make needed acquisitions and improvements to maximize the quality of care provided.

Model A: "Better MED"



- Virtual system with public and private players
- Pharmacy included
- Multiple Community sites
- Outpatient Centers of Excellence retained
- Requires professional liability protection for physicians not in MED system

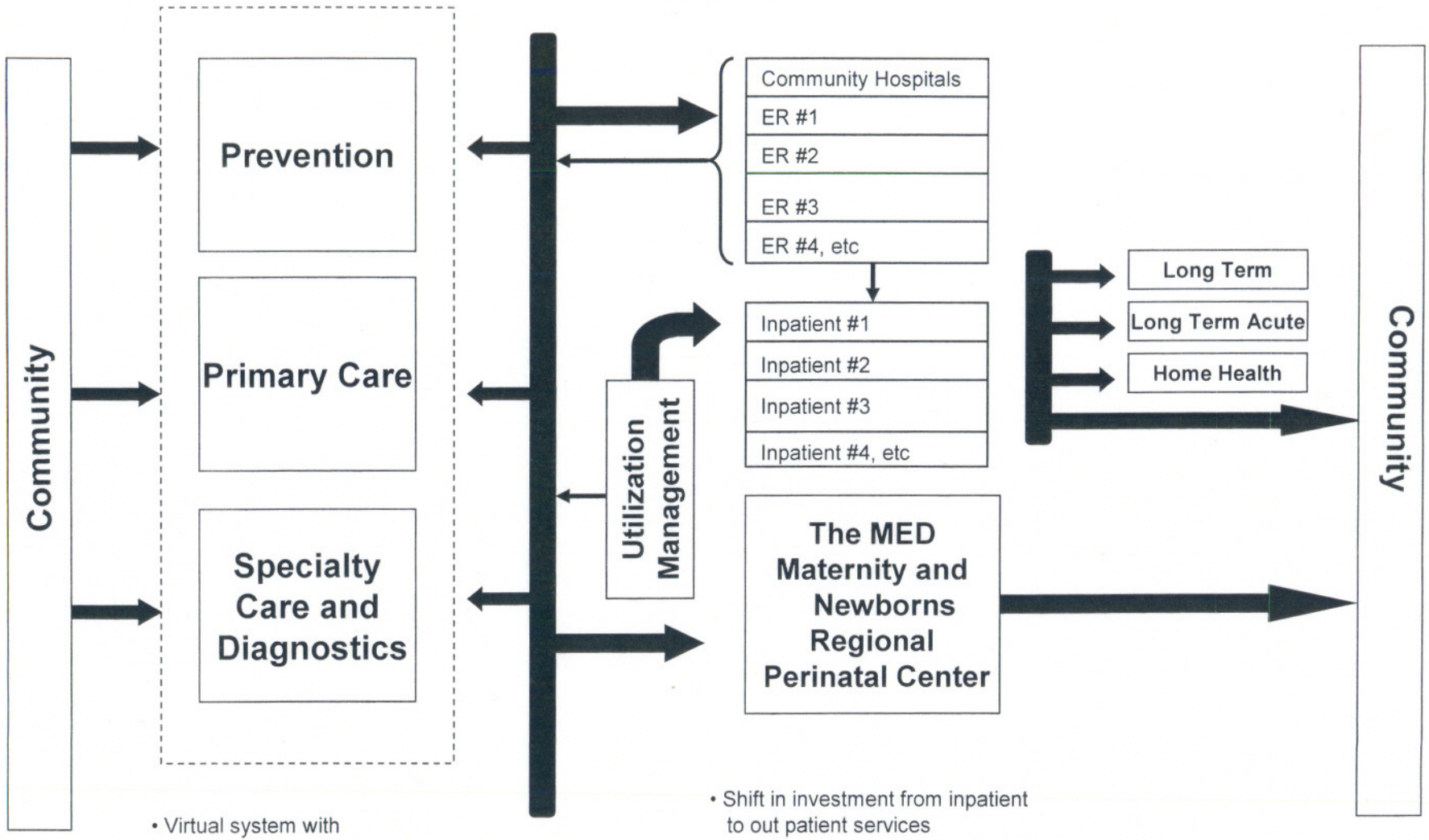
- Shift in investment from inpatient to out patient and post discharge care
- Should result in smaller in-patient bed needs

•Services purchased from community providers

Alternate Model: A-1

Eliminate: Rehab
Wound
Bariatrics
Burn

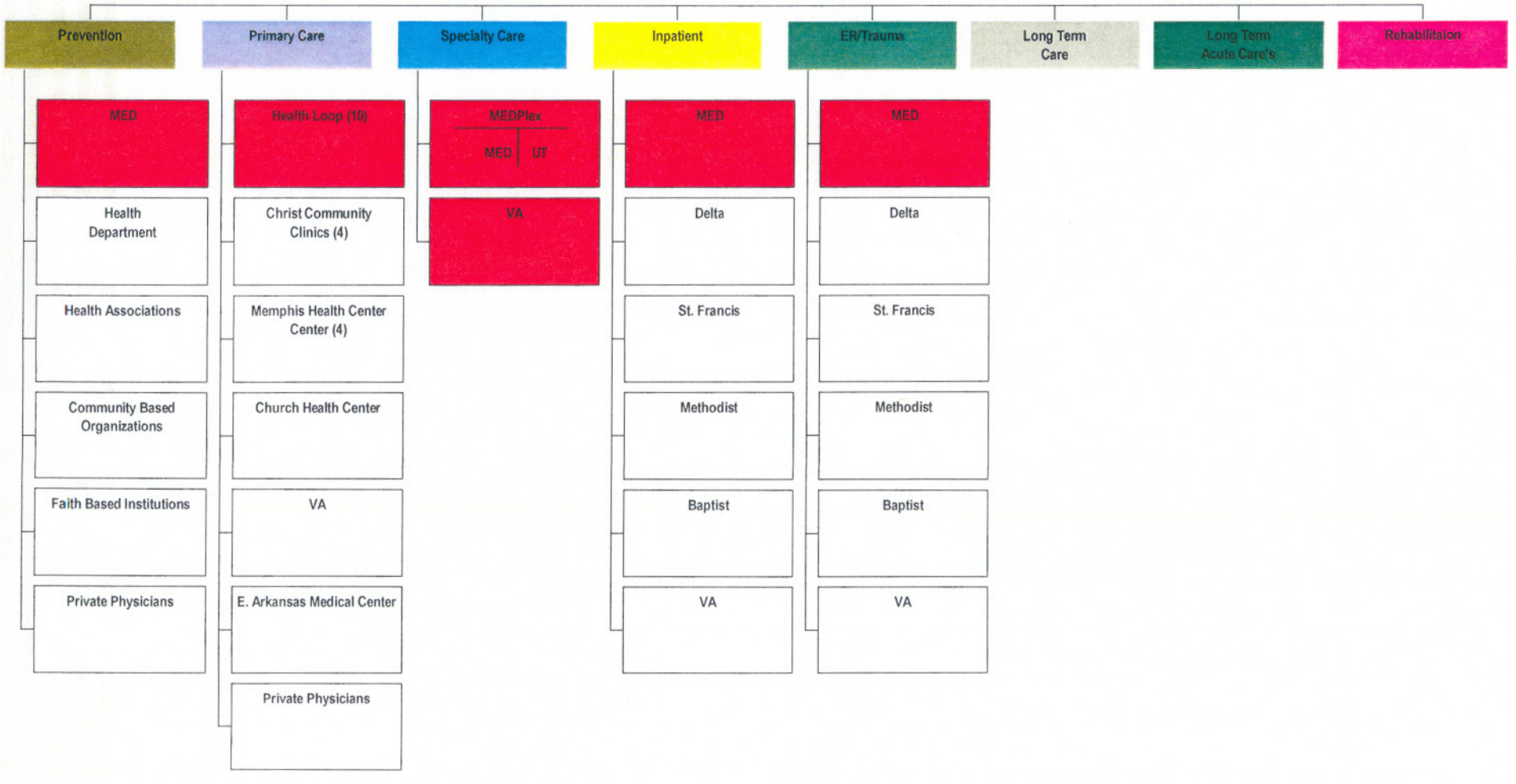
Model B



- Virtual system with public and private players
- Includes Pharmacy
- Multiple community sites
- Outpatient Centers of Excellence retained

- Shift in investment from inpatient to out patient services
- Results in smaller, focused inpatient hospital
- Inmate healthcare and public health in patient services contracted out
- No Level III Trauma Center in this region.
- Referral agreements with area hospitals required
- Capacity of other hospitals?
- Impact on Medical Schools & Residences?
- $ to follow patients

Healthcare Access Points
for
Uninsured and Medically Indigent



FY 2007
TennCare Payments to The Regional Medical Center of Memphis

TennCare Revenue from Managed Care Organizations - $57,958,731
(estimated from unaudited preliminary 2006 JAR)

Supplemental Pool Payments - $34,001,955 in FY 2007

I. Essential Access Hospital (EAH)

a. Total Amount - $100 million (state and federal)
b. Allocation Methodology – Formula rewards high rates of un-reimbursed care, while also taking into account hospital profitability
c. Recurring funding distributed quarterly
d. MED share - $18,567,424 in FY 2007

II. Disproportionate Share Hospital (DSH)

a. Total amount - $31 million (state and federal)
b. Allocation Methodology – Similar to EAH methodology above
c. Non-recurring, but current federal legislative effort underway attempting to add permanent TN DSH
d. MED share – $6,055,580 in FY 2007 (estimated – to be paid this week)

III. Trauma Center

a. Total amount - $13.8 million (state and federal)
b. Allocation Methodology – Temporary rate adjustment to level I, II and III trauma centers
c. Non-recurring, but new trauma pool (to be administered by TDH) created in FY 2008 via $.02 per pack cigarette tax
d. MED share - $2,378,951 in FY 2007

IV. Special State Appropriation

a. Total amount - $15 million (state)
b. Allocation Methodology – Formula rewards high volume of TennCare and charity care, while also taking into account ability to shift cost to commercial payers
c. Non-recurring, but $25 million allocated in FY 2008 (and an additional $5 million for CAH hospitals)
d. MED share - $7 million in FY 2007

New FY 2008 Supplemental Pool

V. Reimbursement Grants for Upgrading Medical Equipment

a. Total amount - $5 million (state)
b. Allocation Methodology – Safety net hospitals with percentage of TennCare days exceeding 35% (MED and Metro General)
c. Non-recurring
d. MED share - $3.5 million

Arkansas History

Regional Medical Center at Memphis

Fiscal Year	Arkansas Self Pay/Medicaid Charges	Cost Charge Ratio	Cost of Services	Less Payments Received	Loss Before UPL	(A) Net Ark UPL Payment	Loss Including UPL	Ark Charges % Total
FY 2004	35,870,349	34.5%	12,384,344	3,371,786	(9,012,558)	-	(9,012,558)	8.66%
FY 2005	38,424,336	30.9%	11,882,189	2,615,509	(9,266,680)	1,302,468	(7,964,212)	7.65%
FY 2006	48,433,874	27.9%	13,521,945	2,434,195	(11,087,750)	1,491,501	(9,596,249)	8.21%
FY 2007 (B)	47,269,201	28.1%	13,273,296	1,619,273	(11,654,023)	987,266	(10,666,757)	8.12%

Notes:

FY07 is 7 months actual data, annualized

Arkansas UPL payments for out-of-state hospitals ended December 31, 2006

Mississippi History

Regional Medical Center at Memphis

Fiscal Year	Mississippi Self Pay/Medicaid Charges	Cost Charge Ratio	Cost of Services	(E) Less Payments Received	Loss Before DSH	(A) Net Miss DSH Payment	Loss Including DSH	Miss Charges as % of Total
FY 2003	$ 23,509,772	42.0%	$ 9,865,754	$ 2,963,037	(6,902,717)	$ 6,123,869	(778,848)	
FY 2004	26,728,514	34.5%	9,228,098	2,146,012	(7,082,086)	10,009,689	2,927,603	9.51%
FY 2005	39,856,199	30.9%	12,324,973	4,450,431	(7,874,542)	7,127,859	(746,683)	9.88%
FY 2006	59,818,828	27.9%	16,700,438	4,993,445	(11,706,993)	8,328,863	(3,378,130)	11.44%
FY 2007 (B)	49,597,909	28.1%	13,927,202	3,012,610	(10,914,592)	2,399,392	(8,515,200)	10.33%

Notes:

A. The Mississippi DSH payments applied to services rendered to Self Pay and Medicaid patients three (3) years in arrears.

B. FY07 is 6 months actual data, times 2

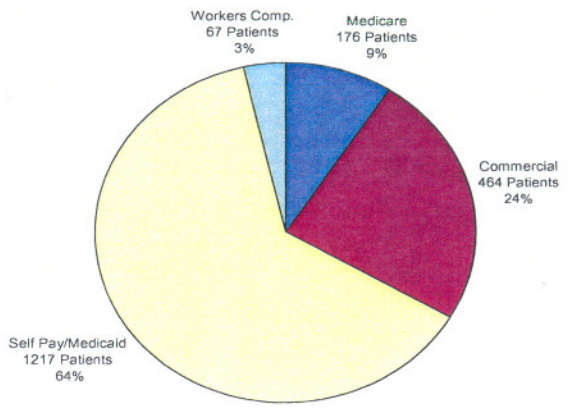
C. Mississippi DSH payments for out-of-state hospitals ended December 31, 2006

D. Days Cash on Hand as of January 31, 2007 was 16.8.

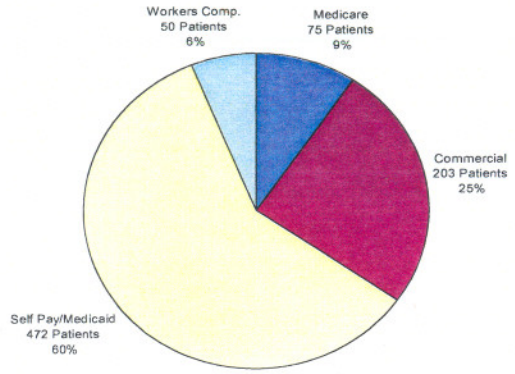
E. Represents all payments from all sources for patients classified as Self Pay and Medicaid.

The Regional Medical Center at Memphis
Health Care Provided to Arkansas Residents
FY 06

Payor Mix - All Arkansas Patients



Payor Mix - Arkansas Patients - Trauma, Burn and Neonatal ICU



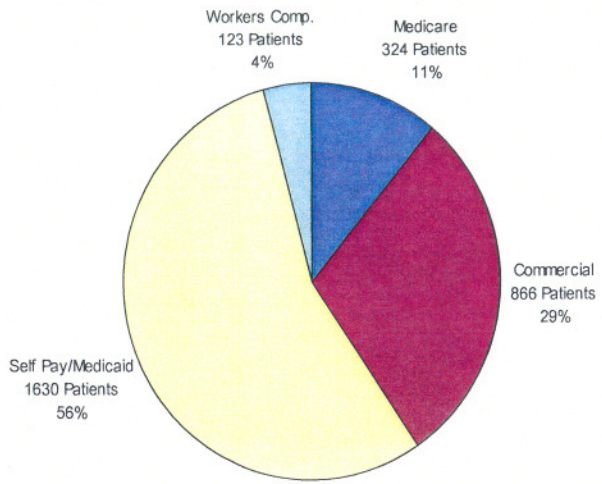
Self Pay/Medicaid	Hospital Cost	Payments	Loss
Trauma/Burn/NICU	10,618,097	1,566,060	(9,052,037)
Other Services	2,904,641	765,229	(2,139,411)
Total	13,522,738	2,331,289	(11,191,448)

Patients by County

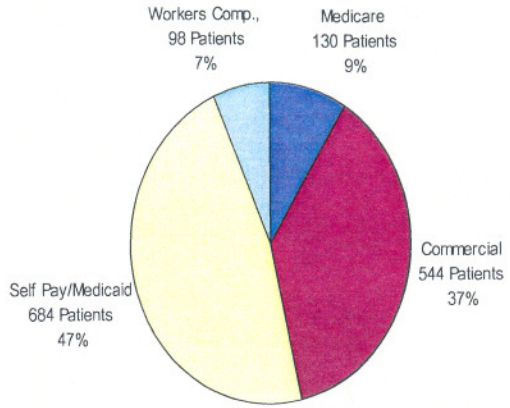
County	*Patients*
Crittenden	864
Mississippi	219
Saint Francis	142
Craighead	121
Phillips	73
Poinsett	72
Greene	54
Lee	37
Pulaski	37
Yell	34
Randolph	21
All other Counties	250
Total	1924

The Regional Medical Center at Memphis
Health Care Provided to Mississippi Residents
FY 06

Payor Mix - All Mississippi Patients



Payor Mix - Mississippi Patients - Trauma, Burn, and Neonatal ICU



Self Pay/Medicaid	Hospital Cost	Payments	Loss
Trauma/Burn/NICU	13,579,989	3,588,445	(9,991,544)
Other Services	3,120,449	1,405,000	(1,715,449)
Total	16,700,438	4,993,445	(11,706,993)

MS Patients by County

County	Patients
Desoto	1214
Marshall	298
Panola	205
Tate	203
Tunica	154
Coahoma	109
Lafayette	54
Yazoo	51
Bolivar	49
Alcorn	48
Yalobusha	38
Lee	37
All other Counties	483
Total	2943